

INDIANA STATE DEPARTMENT OF HEALTH
Microbiology/Rabies Laboratory
P.O. Box 7203
635 N. Barnhill Drive
Indianapolis, IN 46207-7203
Phone (317) 233-8040
Fax (317) 233-8063

PLEASE TYPE OR PRINT LEGIBLY

1 LLAGE 111 L OIL	I MINI EFOIDE					
REQUIRED PATIENT INFORMATION				PLEA Indiana State Departi	1.2	
Name (Last)	(First)	Age	Sex	Facility Name		
Address		<u></u>	L	Address		
City	Z IN	ip Code		City	IN	Zip Code
Attending Physician			,	Contact Person		
Address				Phone Number	Fax Nun	nber
		SPECI	IMEN IN	NFORMATION		
Date Collected:			haryng	eal (Preferred):		
Was the tube incubat ☐ Yes hou	ed prior to shipment?	Comm	Yes	Other (please spec	ify):	
	CON		BLE DI	SEASE STATISTICS		
Date Of Onset: An	timicrobial Therapy Begun: ☐ Yes ☐ No	If Yes,	, indicat	e drug:	Date Started:	Date Ended:
Pertussis Vaccination Yes		Dates	:			
	··· DO	VOT WR	{ = B =	LOWTHESELINES		
		LAB	ORATO	RY REPORT		
Р	RELIMINARY REPORT:		<u></u>	F	FINAL REPORT:	
Date:		·				
☐ DFA test NEGA	TIVE			Test Results for Borde	etella: 🔲 DFA	☐ Culture
☐ Bordetella perti	ussis 🗌 Bordetella j	parapen	tussis	☐ NEGATIVE ☐ P	OSITIVE	NO GROWTH
				☐ Bordetella pertuss	sis 🗌 Bordet	ella parapertussis
☐ DFA test POSIT	IVE	-				
☐ Bordetella perti	ıssis 🔲 Bordetella p	parapen	tussis	☐ Unsatisfactory		
☐ Further studies	in progress; final report	will foll	ow	☐ Comments		
				Lab Number:	Date Received:	
				Date of Final Report:		
				☐ Copy to EPI Resou	irce Center	

INSTRUCTIONS

Fill out completely the upper half of the request form on the reverse side. <u>TYPE OR PRINT CLEARLY.</u> The report will be a photocopy returned in a window envelope to the "Name and Address for Report" the patient's physician or other appropriate medical official.

SPECIMEN COLLECTION AND TRANSPORT:

1. To take the specimen, immobilize the patient's head and gently pass the swab through the nostril into the nasopharynx.

IT IS NECESSARY TO OBTAIN TWO SPECIMENS RATHER THAN A SINGLE ONE

2. Once the specimens have been taken, prepare 4 smears (2 <u>SEPARATE SLIDES</u>) by rolling the swab to cover the entire circle.

ROLL SWAB TO MAKE SMEAR ON SLIDE

3. Place the swabs in the tube containing the semisolid transport media. Be sure to immerse the swab completely in the media. Snip wire, and re-cap tightly.

LEAVE SWAB IMMERSED IN THE MEDIA FOR TRANSPORT

- 4. AIR-DRY the prepared slides. Replace dry smears in plastic slide holder (2 per holder).
- 5. <u>RETAIN THE INOCULATED TRANSPORT MEDIA AT 35 DEGREES C, FOR 18 TO 48 HOURS until ready to transport.</u>

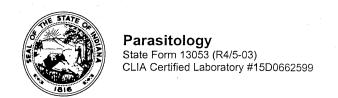
If unable to incubate, hold refrigerated until ready to package and mail. <u>RECORD THIS INFORMATION on the front of the form within the comments area.</u>

When ready to ship, put the dried slides into the plastic slide holder and place it and the inoculated transport media into the metal container and secure the screw cap tightly.

Fold the completed patient submission form in half twice_(bottom and top) and roll it around the metal container.

Insert that into the outer cardboard container and securely tighten the screw cap before mailing.

- 6. Be sure to give complete patient information including immunization records and antibiotic therapy. DO NOT USE KITS if expired, leaky, broken, or contaminated.
- 7. It is <u>RECOMMENDED</u> to send the specimen to the laboratory 24 hour-next day delivery. It will insure expedited transport, faster DFA results, and better recovery.



INDIANA STATE DEPARTMENT OF HEALTH Clinical Microbiology P.O. Box 7203 635 North Barnhill Drive Indianapolis, IN 46207-7203

Phone (317) 233-8045 Fax (317) 233-8063

Patient's Name (Last)	(First)			Age	Sex
Patient's Address				County	
Attending Physician (if not include	ded below)	Address	S	,	
Required Sp	ecimen Information			Print or Type) ddress for Report	
Date Collected		The state of the s		·	
First Patient Specimen?	☐ Yes ☐ No				
Type:	Purpose:	· · · · · · · · · · · · · · · · · · ·			
Feces	☐ Diagnostic	and the second 	City	INZi	p Code
	Release				
(specify) Other Comments:	☐ Carrier ☐ Outbreak	Contact Person Phone Number (Fax Number ()		
Instructions are on the revers	se side LABO	RATORY REPO	ORT	Do not write be	ow this line
ab No	Date Received		Date	e of Final Report	
No trophozoites, cysts, o	or ova of intestinal parasites fou	nd			
•					
	resubmit for reasons below:				
•					

PARASITOLOGY

Submission of Specimens – ISDH Container No. 4A – Intestinal Parasites: Examination of fecal specimens for amoeba and other protozoa. <u>Cryptosporidium</u> sp. will be tested upon request.

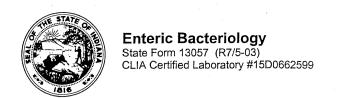
IMPORTANT: Mailing container contains one request form, a plastic spoon, and two specimen bottles: one contains 10% Formalin and the other (PVA) Polyvinyl Alcohol fixative.

- A. Both solutions are poisonous if taken internally. Do not eat or drink solutions. Any spills should be absorbed with paper towels and discarded as trash. If fluid contacts the skin, wash with soap and water. If fluid contacts eyes, flush with water for several minutes.
- B. Kit must be used by the expiration date stamped on the outside of the mailing label. Kits exceeding the expiration date will not be tested. Submitter agencies should return expired kits to the ISDH for recycling.
- C. Write NAME and SPECIMEN COLLECTION DATE on both the REQUEST FORM AND COLLECTION BOTTLES. Without this complete information the specimen WILL NOT BE TESTED.
- D. Carefully proceed as follows.

INSTRUCTIONS

- 1. Fully complete the upper half of the request form. Please type or print clearly.
- 2. Feces must be added to EACH bottle.
- 3. Collect feces in a clean bedpan, plate, cardboard container, or paper or plastic cup. (DO NOT MIX URINE WITH FECES)
- 4. Using the plastic spoon, place a portion of feces the size of a quarter into EACH bottle.
- 5. Carefully break up and stir the feces in each bottle. Screw the caps on <u>tightly</u> and shake vigorously to further blend the specimen. Place into metal container and tighten screw caps.
- 6. DISCARD THE PLASTIC SPOON PROPERLY ----- DO NOT return the spoon to the laboratory.
- 7. Fold and wrap the completed request form around the outside of the metal container and place both into outer mailing tube. Tighten screw cap firmly. Mail **PROMPTLY** and unrefrigerated via the U. S. Postal Service (USPS) First Class Mail to the laboratory.
- 8. The maximum in-laboratory turn-around time for Parasitology specimens is 6 working days. The usual examination time is 1-2 working days after receipt. The submitter should allow sufficient transit time for the USPS to deliver results. Results will be sent as photocopies of the original report.

INDIANA STATE DEPARTMENT OF HEALTH Clinical Microbiology Phone (317) 233-8045 Fax (317) 233-8063



☐ Copy to ISDH Epidemiology Resource Center

INDIANA STATE DEPARTMENT OF HEALTH Clinical Microbiology P.O. Box 7203 635 North Barnhill Drive Indianapolis, IN 46207-7203

Phone (317) 233-8045 Fax (317) 233-8063

Patient's Name (Last)		(First)		Age	Sex	
Patient's Address				4	County	
Attending Physician (if not include	ed below)	Ä	Address			
Required Speciments Date Collected		tion		(Please Print or Type) e and Address for R		
First Patient Specimen? [TYPE: Feces (specify)	Diagno Releas Carrier Contac	e)	INZip Code	
Instructions are on the Reve	Instructions are on the Reverse Side LABORATO			ORY REPORT Do Not Write Below These Lines		
Lab No.	Date Receiv	ed:	Intl:	FINAL RI		
PRELIMII Date	ed. Final identi	fication report	O157:H7 isolat No Growth on E No Clostridium sp. Reference Labo Bacillus sp. isolat Laboratory will f Campylobacter Escherichia coli Salmonella sero Shigella sonnei	Enteric Media or Bacillus sp. isolated isolated. Final report froi oratory will follow ated. Final report from the ollow jejuni O157:H7	m the ne Reference	
			☐ Unsatisfactory –	- Please resubmit.	Туре	

ENTERIC BACTERIOLOGY

IMPORTANT INFORMATION

Submission of Specimens – ISDH Container No. 7A – Enteric Bacteriology: Examination of Fecal Specimens for enteric pathogens.

Specimens are routinely examined for Salmonella, Shigella, Campylobacter, and E. coli 0157:H7. Rectal swabs cannot be examined due to inadequate material. For other enteric pathogens and/or additional information, please call (317) 233-8045.

Before using kit, check the expiration date of the container. **Do not use kit past the expiration date or specimen will not be tested.** If you have expired kits, notify the facility from which they were acquired and request an exchange. Please return expired kits to ISDH for recycling.

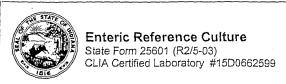
The mailing container includes a request form, a spoon for handling the fecal specimen, and one specimen bottle, labeled *Cary Blair*. Do not use this kit if it does not contain the specimen bottle. Feces must be added to the preservative. Handle the bottle carefully to avoid spilling or splashing the contents. Any spills should be absorbed with paper towels and discarded as trash. If the fluid contacts the skin, wash with soap and water. If fluid contacts the eye, flush with water for several minutes. The fluid is not poisonous, but could be an irritant to sensitive individuals. Return any spilled kits to the facility from which they were obtained.

INSTRUCTIONS 7A ENTERIC CONTAINER PLEASE READ AND FOLLOW CAREFULLY

- 1. Fill out the upper half of the request form completely including patient name and collection date.

 TYPE OR PRINT CLEARLY. The report will be returned to the health care provider whose address is in the space designated for Name and Address for Report.
- 2. Collect feces in a clean, dry container such as a plastic cup. **DO NOT MIX URINE WITH FECES.**
- 3. Open the inner container, remove the specimen bottle, and remove the screw cap. Use the plastic spoon to pick up ONLY TWO HEAPING SPOONSFULL of solid feces or FOUR SPOONSFULL IF THE SPECIMEN IS LIQUID. Place the feces into the open bottle, secure cap VERY TIGHTLY (write the patient name and collection date on the bottle or the specimen will not be tested). Replace the bottle into the metal container and secure the metal screw cap firmly.
- 4. DISCARD THE PLASTIC SPOON AND REMAINING FECES.
- 5. Fold and wrap the completed request form <u>around the outside</u> of the metal container and place into the outer mailing tube. Secure lid firmly. Mail or transport **PROMPTLY** and unrefrigerated to the laboratory.

INDIANA STATE DEPARTMENT OF HEALTH
Clinical Microbiology
Phone (317) 233-8045
Fax (317) 233-8063



Indiana State Department of Health Clinical Microbiology P.O. Box 7203 635 N. Barnhill Drive Indianapolis, IN 46207-7203 (317) 233-8045

Patient Information:	Indianapolis, IN 46207-7203 (317) 233-8045
Name	
Address County	Name & Address for Report
Age Sex M or F Date of Onset	
Attending Physician	
Address	
Address	
Required Culture Information:	Send Report c/o
Source:	Phone ()Fax ()
Date:Isolated:Submitted:	Remarks
Suspected Organism	
()SA ()SH ()OT	
DO NOT WRI	TE BELOW THIS LINE
LABORA	ATORY REPORT
ISDH Lab Number Date Received	Final Report Date By
Preliminary Report DateBy	() Salmonella serotype
() Escherichia coli 0157 (H7 results pending)	Serology:
() Presumptive	group antigenic pattern
() Identification in Progress	() Salmonella() Shigella sonnei
	() Shigella
	type
	() Negative for Escherichia coli 0157 () Escherichia coli 0157:H7
	()
() Copy to ISDH Epi	demiology Resource Center

ENTERIC REFERENCE CULTURE

INSTRUCTIONS

CULTURE INFORMATION FROM SUBMITTING LABORATORY

1. Submit an 18-24 hour PURE SINGLE COLONY CULTURE	A. Identification
TRANSFER on a nutrient or infusion agar slant using a screw cap tube.	B. Serology Results
TO THE PURPOSE OF THE PROPERTY OF A CAP DI ATER	C. Rapid Method Kit Used

DO NOT SUBMIT CULTURES IN BROTH OR AGAR PLATES

2. Fill out the request form, front and back, as completely as possible. TYPE OR PRINT LEGIBLY. THE NAME OF THE PATIENT AND COLLECTION DATE IS REQUIRED ON BOTH THE TUBE AND FORM. On the front side check probable identification:

> SA for Salmonella SH for Shigella **OT** for other

- 3. Pack the culture securely in an approved container to meet the current transportation (D.O.T.) regulations for mailing infectious substances. Tighten screw caps.
- 4. The report will be a photocopy of the front side of this form, and returned to the health care provider whose address is in the space designated "Name and Address for Report".

BE CERTAIN THAT YOUR ADDRESS IS COMPLETE SO IT IS RETURNED TO THE SPECIFIC SENDER.

A preliminary report will be forwarded only if there are significant preliminary findings or extended identification studies involved. FAX reports are not routinely sent.

A. Identincation		
B. Serology Resul	its	
C. Rapid Method I	Kit Used () YES	()NO
•	Profile#	•
	- Oxidase +	
Othe	er Information or Co	mments

Indiana State Department Of Health Clinical Microbiology Phone (317) 233-8045 Fax (317) 233-8063



Lab Number

Reference Bacteriology Culture Identification SF 35898 (R3/10-01)

CLIA Certified Laboratory #15D0662599

Mail/Fax Copy of the Report to Communicable Disease

INDIANA STATE DEPT. OF HEALTH LABORATORIES MICROBIOLOGY LABORATORY 635 N BARNHILL DR. RM 2023 P.O. BOX 7203 INDIANAPOLIS, IN 46207-7203

REFERENCE BACTERIOLOGY LABORATORY (317) 233-8040 Fax (317) 233-8063

Date of Final Report

RETURN THIS ORIGINAL FORM WITH THE SPECIMEN, NOT A COPY REQUIRED PATIENT INFORMATION Name (Last, First, Middle) Address Gender Date of Onset Age Physician Diagnosis REQUIRED CULTURE INFORMATION Isolation Source Date Isolated Date Submitted **EXAMINATION REQUESTED** Organism Suspected Identification Confirmation SUBMITTER INFORMATON **Facility Name** Address City Zip Code Phone Number Fax Number IN Comments: DO NOT WRITE BELOW THIS LINE **FINAL REPORT** Comments:

INSTRUCTIONS

The 10A container conforms to all State and Federal laws pertaining to the transport of etiologic agents. If other containers ar used they must also conform to postal laws. The ISDH will reserve the right to refuse and/or discard any specimen(s) received i an inadequate or unsafe container. Submit only PURE CULTURES that are to be identified. Mixed cultures may not be accepted It is best to make submissions on a low carbohydrate medium free of excess moisture. For ANAEROBES use stab cultures in low carbohydrate medium or sealed chopped meat broth. FASTIDIOUS ORGANISMS can be sent as a heavy growth or either blood agar or heart infusion slant.

DO NOT SEND CULTURES ON PETRI PLATES

Complete the top portion of this form. After packing the specimen in the inner container wrap the form around it, insert into the outer container, and affix the screw cap.

Check "REFERENCE BACTERIOLOGY" on the container address label to assure prompt delivery to the proper laboratory.

1. The Reference Bacteriology Laboratory services are available to Indiana medical facilities.

Date Specimen Received

2. An effort on the part of the submitting laboratory to identify the isolate must have been made and those results made available to us upon request.

REFERENCE BACTERIOLOGY WORKSHEE

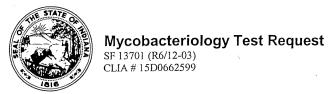
Date Received:

Date Set Up:

Lab Number:

DATE OF OBSERVATION / INITIAL							
TEST READ DATE			TEST READ DATE				
TEST SET DATE			TEST SET DATE				
							
GRAM REACTION/MORPH.			LECITHINASE / LIPASE	T		T	T
BLOOD REACTION			BILE GROWTH PY				
ATM. REQ. (O ₂ / CO ₂ /ANO ₂ / 5%O ₂))		CHOPPED MEAT DIGEST				
COLONY MORPHYLOGY			THIO GEL				
MOTILITY			IRON MILK				
OXIDASE CATALASE	+		CASEIN HYDROLYSIS	 			-
OF FERM CTA			TYROSINE HYDROLYSIS / PIGMENT	+			_
GLUCOSE			TINSDALE HALO	 - - - - - - - - - 			+
XYLOSE			COAGULASE RABBIT PLASMA	+		-	+
MANNITOL			FX 100 / BA 10 / NB 5 / PB 300	1		1	
LACTOSE			DNASE / THERMONUCLEASE				
SURCROSE			ONPG				
MALTOSE			PYR				
FRUCTOSE	++		STARCH HYDROLYSIS				
	 		STARCH HTDROLTSIS	 		 	-
MacCONKEY	+		OF FERM CTA	 		+	+
SS			ADONITOL			1	
CETRIMIDE			AMG			1	1
SIMMONS CITRATE			AMYDALIN				1
CHRISTENSEN'S UREA			ARABINOSE (L)				
NO₃ REDUCTION/GAS			CELLOBIOSE				
NO₂ REDUCTION/GAS			DULCITOL				
INDOLE			ERYTHRITOL			<u> </u>	<u> </u>
TSI SLANT/BUTT	 		GALACTOSE GLYCEROL				ļ
TSI H ₂ S BUTT/PAP			INOSITOL	 		 	ļ
VP	 		INULIN			+	
GELATIN HYDROLYSIS			MANNOSE	 		 	
LITMUS MILK			MELEZITOSE			+	
PIGMENT			MELIBIOSE				1
GROWTH 25°C			METHY-MANNOSE				
GROWTH 35°C			RAFFINOSE				
GROWTH 42°C			RHAMNOSE				ļ
GROWTH °C ESCULIN HYDROLYSIS	 -		RIBOSE			 	
LYSINE DECARBOXYLASE	+		SALICIN SORBITOL	 		 	
ARGININE DIHYDROLASE	 		SORBOSE			 	
ORNITHINE DECARBOXYLASE			STARCH	 	-	 	<u> </u>
NUTRIENT BR. 0% NaCl Growth			TREHALOSE			 	
NUTRIENT BR. 6% NaCl Growth			TURANOSE				
THAYER MARTIN GROWTH			XYLITOL				
LOEFFLER DIGEST/PIGMENT							
AMYLOSUCRASE XV REQUIREMENT				·		ļ	
PORPHYRIN						ļ	
ACETAMIDE	 						
SODIUM ACETATE							
PROPINATE						اا	-
ANAEROBIC ALK. NO ₃							
PHENYLALANINE/ MALONATE			Preliminary ID by GLC Analysis / D	ate / Initial			
BACITRACIN / OPTOCHIN							
BILE SOLUBILITY							
BILE ESCULIN			Final Identification / Date / Initial				l
6.5% SALT TOLERANCE METHYLENE BLUE HYDROLYSIS			-				
HIPPURATE HYDROLYSIS							
TELLURITE / TETRAZOLIUM	 		1				
6 µg VAN/ML GROWTH							
			1				
			·				

(+)positive (-)negative (A)acid (K)alkaline (pep)peptonization (±)weak,slight positive (d)delayed (S)sensitive growth (R)resistant growth (IR)indicator reduced (W)weak (NG)no growth (NR)no reaction (mm)millimeter



	LAST	FIR	T	BIRTHDAT	F		SEX
PATIENT NAME		<u> </u>	<u>=</u>	M			
ADDRESS		COUNTY					
PHYSICIAN		MI	O ADDRESS				t.
DATE COLLECTED		SPECIME	N SOURCE	ANTI-MYCOBAC	CTERIAL	THERA	APY
	() SPUTUM			() NONE () STR	() IS	О
	() CULTURE FOR ID		•)PZ	
			T				
	Sender Comments		<u>Na</u>	me and Address for Re	port		
	,	•					
	• •						
			·			t	
		DO NOT WRITE	BELOW THIS LINE		· .		
		DO NOT WRITE	DELOW THIS LINE				
MICROSCOPIC EX	<u>KAMINATION</u>	IDENTII	FICATION	SIRE BACTEC	SUSCEPT	IBILIT	<u> Y</u>
Auramine-O Stain (40	00X)	Mycobacterium		ŀ	µg/ml	S	R
Acid Fast Bacteria		() tuberculosis comple	x	STREPTOMYCIN	2.0		
() Not Found		() avium complex					
() Found		() chelonae		ISONIAZID	0.1	· · · · · · · · · · · · · · · · · · ·	-
() < 1 per field		() kansasii					
() 1-10 per field		() xenopi		RIFAMPIN	2.0		
() > 10 per field		() fortuitum					
() SPECIMEN UNSATISE	FACTORY	() gordonae ()		ETHAMBUTOL	2.5		
		() Not isolated () Culture is contamina	sted, more time required	PYRAZINAMIDE	100		
DateBy_		() Overgrown	•	S=Susceptible R=Re	esistant		
		() Culture sent to CDC		Date			
		Date	_ By	Ву	_		
				ISDH CO	<u>OMMENTS</u>		
					Í		
Lab No	_ Date Received						
() Copy to TB Control		☐ FINAL REPO	DRT				

MYCOBACTERIOLOGY (Examination for Tuberculosis)

Complete the top part of the request form. TYPE or PRINT legibly with black ink. The final report will be a photocopy of the front side only, returned to the submitting facility.

Submission of Clinical Specimens (ISDH Container No. 6A – Tuberculosis)

- 1. Collect sputum early in the morning BEFORE the patient eats or drinks. It should be raised from the lungs, not saliva, and deposited directly into the furnished plastic container. Do not fill the plastic container more than half full. Wipe off any sputum from the outside of the plastic container before shipment.
- 2. After collection, tighten the cap to avoid breakage and leakage and place in the metal container.
- 3. Enclose the completed request form in the outer cardboard mailer along with the aluminum container and forward to the laboratory promptly.

Note: If gastric washings are to be submitted, you must neutralize the washings to about pH 7 within 30 minutes after collection or the organisms will die.

Submission of Cultures

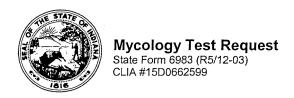
- 1. Submit a pure culture on a tubed slant of mycobacterial culture medium, preferably Lowenstein Jensen.
- 2. Pack the culture to prevent breakage and to conform to USPS and DOT regulations for "Interstate Shipment of Etiological Agents," 49 CFR 173.196. Wrap the culture in absorbent material, place it in an inner container along with the request form and enclose securely in an outer shipping container. Do NOT send or deliver cultures grown on Petri plates; they will not be accepted.
- 3. The outer shipping container must be marked with the international biohazard symbol. Secure the outer container and write "MYCOBACTERIOLOGY" on the address label to assure prompt delivery to the laboratory.

Test Service Information

- 1. All samples received with completed paperwork are tested. If there is a problem with your submission, you will be promptly notified by telephone, mail, or both.
- 2. Drug susceptibly testing procedures are performed on <u>M. tuberculosis</u> only. Drug susceptibility testing on other species may be performed after consultation with laboratory personnel.
 - a. Bactec 460 S.I.R.E testing requires approximately 1 week too complete. This procedure is automatically performed for new patients and on patients who remain culture positive after 3 months of treatment.

Indiana State Department of Health Clinical Microbiology 635 N. Barnhill Drive Indianapolis, IN 46202 Phone: (317) 233-8042

Fax: (317) 233-8043



Date Received	ISDH Lab Number
	· · · · · · · · · · · · · · · · · · ·

Indiana State Department of Health Clinical Microbiology P.O. Box 7203	. Patient Last Name	First Name	М	Age	Sex
635 N. Barnhill Drive, Room 2023 Indianapolis, IN 46207-7203 (317) 233-8044 SEND REPORT TO:	Source				-
Contact Person:	Date Submitted Type				
Phone Number: ()Ext					
INITIAL REPORT Date By	FINAL REPORT Date	Ву	_		
 () Gram Stain Negative () Gram Stain Positive for Fungal Forms () Specimen cultured; allow 2-4 weeks or longer () Culture received; identification in progress 	 () Fungus not Isolated () Specimen/Culture Unsati () Organism(s) Isolated/Idea () Identified by Exoantigen () Identified by GenProbe 	ntified:			
PROGRESS REPORT DateBy	FINAL IDENTIFICATION				

() Copy to Chronic and Communicable Disease

MYCOLOGY

(Examination for Fungi)

INSTRUCTIONS

Fill out the request form as completely as possible. TYPE OR PRINT LEGIBLY. The report will be photocopy of the front side only, returned in a window envelope to the address you transcribe in the "Send Report To" box. The name or ID number of the PATIENT IS REQUIRED.

Submission of Cultures - PROVIDE OWN APPROVED MAILING CONTAINER

- 1. Submit a pure culture on an agar slant. Use a screw-capped tube only. PETRI DISH OR BROTH CULTURE SUBMISSIONS ARE UNSATISFACTORY AND WILL BE DISCARDED UPON RECIEPT.
- 2. Pack the culture in absorbent material to prevent breakage and leakage, place in an inner container assuring that it is tightly fastened. Fold and enclose the request form along with the culture securely in the outer mailing container, affix first class postage and mail promptly. All materials must meet the packaging requirements in 49 CFR 173.196 (USPS and DOT regulations for "Interstate Shipment of Etiological Agents").
- 3. The outer shipping container must be marked with the international biohazard symbol. Please write "MYCOLOGY" on the address label to avoid delays in delivery to the laboratory.